Peter Miller

N306J

10/2/10

Case Study #1

1. A. The first problem I see with the medication order is that the amount in weight of the Percocet is not listed in the orders. All the order says is to give two Percocet every four hours.

   B. The next problem I see also concerns the Percocet order. The route is not mentioned at all either on this order for Percocet. The patient does take this at home, but the dosage could be different from what she had at home.

   C. The Tylenol #3 dosage is missing as well with these medication orders. All that is known is that she would get 1-2 by mouth. We also don't know what form these medications come in. They could be capsules, chewables, or tablets.

   D. The last thing would concern the verbal orders for the IV morphine 2 mg. There seems to be an issue with the documentation of this medication. There were several orders for this and it seems like no action was taken at all. The only thing she was given were the PO medications. That order should have relayed a lot better so it could have been received by the patient.

   E. Also, the type of morphine used is not specified. By just saying morphine, it can be confused by the nurse and needs to be much more specific.

   F. Another barrier that I see is the lack of modifiers for which amount and drug to use for types of pain: mild, moderate, severe.

2. A. The order is for 10-15mg of morphine PO q4-6h which would produce a daily dose of anywhere between 40mg and 90mg daily.

Jason Lohmeyer 10/11/10 8:12 AM
Comment: No dose is provided – remember Percocet comes in just a few doses – the MD needs to clarify

Jason Lohmeyer 10/11/10 8:13 AM
Comment: After studying the Mod 3 content you should remember that Percocet (oxycodone/APAP) only comes PO.

Jason Lohmeyer 10/11/10 8:14 AM
Comment: You should understand that 2mg IV morphine is hardly equally to the patients 2 Percocets that she was taking at home – she is being underdosed

Jason Lohmeyer 10/11/10 8:15 AM
Comment: How many kinds of morphine are there? It is the route that differs: MS is available PO, PO ER, Rectal supp, buccal, IV, SQ...

Jason Lohmeyer 10/10/10 1:48 PM
Comment: when to use prn vs. non-prn dosing; discuss the problems associated with the use of dosing ranges. The problems with the orders as written include a) range of doses, b) range of dosing intervals, c) prn dosing for continuous pain, d) use of descriptors--mild, moderate, severe.

Jason Lohmeyer 10/11/10 8:22 AM
Comment: No work is shown
Peter – the question is asking the equianalgesic conversion of 2 Percocet therefore none of your answers are correct
-8

b. The oral dilauded should be given 2-4 mg PO q4-6 hours as well which would produce a range of between 8mg and 24mg daily of dilaudid.

c. IV MS infusion should be either given as a PCA or at a rate of 2-10mg every 4 hours. The total daily dosage would be between 8mg and 40mg of IV Morphine Sulfate daily (Nursing 2009 Student Drug Handbook).

Jason Lohmeyer 10/11/10 8:21 AM
Comment: this would be run as a continuous infusion thus 1mg/hour is the rate

3. Depending on the route of the medication, analgesia should take effect within a short amount of time. Once it reaches therapeutic levels in the blood, it should be able to elicit an analgesic effect. Analgesia though an intravenous route will obviously take a much shorter time to produce results than by mouth. Through IV, effects should take less than 5 minutes and by mouth less than 1 hour until results should be seen (2009 Nursing Drug Handbook).

Jason Lohmeyer 10/11/10 8:23 AM
Comment: Discuss a reasonable time frame in which to expect better analgesia: certainly within the first 1-2 hours a patient in severe pain should be at least 50% improved and have improvement in ADL's. The important point is that the dose of opioid can and should be adjusted frequently within the first few hours if pain is not quickly relieved. If rapid dose adjustments fail to make any impact then other measures will be needed.
-2

4. The major principle for giving analgesia is to "start low and go slow." Opioids can have some serious side effects and by starting at too much and pushing too fast, it can cause respiratory depression very quickly. Peak and trough levels should be drawn, but the major indicator of pain control is how it is helping the patient and the signs and symptoms that are elicited (2009 Nursing Drug Handbook). Generally, when the dosage needs to be increased, the dosage should go up in percentages, with mild pain increasing at slower rate (25% at a time) and for moderate to severe pain at faster rates (50-100% at a time).

Jason Lohmeyer 10/11/10 8:24 AM
Comment: have you ever seen a morphine level drawn – this is not done.

Jason Lohmeyer 10/11/10 8:25 AM
Comment: As a general rule, for moderate-severe pain dose escalate by 50-100%; for mild pain increase by 25% . Always dose escalate by a percentage of the prior dose (no matter what the current basal dose is). Short acting opioids (MSIR, Oxycodone, Dilaudid) can be dose escalated q1hr, while MS Contin/Oramorph SR/Oxycontin q 24 hr; the Fentanyl Patch and methadone can be dose escalated no more frequently than q 48-72h. When IV infusions are increased a bolus dose should be given to rapidly increase blood levels.

Case Study #2

1. The one obvious major concern that I would have as the staff nurse is that the man may become addicted to the opioids that could be prescribed. On the other hand, it is important that we control his pain because there is no doubt he has a real condition going on. Without his pain controlled, he will most certainly be putting a ton of stress on the nurses caring for him, which will cause the nurse to neglect care for his or her other patients. The pain should be what the patient says it is. I understand he has a history of drug abuse, but when he says he is in pain and bothering others, some intervention must be done to control this.
2. It is very difficult to consider this patient a drug addict at the time. He does have a very real disease going on in his body. It is really difficult to determine this with the information given. No measures at all so far have seemed to do anything for his pain. The oxycodone should provide some relief as it is a form of an opioid analgesic. He is compulsively complaining about the pain no matter what is given to him. To determine if he is an addict or not, his mannerisms should be watched and studied to see if he is only in pain when the nurse comes through the door. This is very difficult because the Herpes Simplex in his throat would cause a lot of pain. Personally, I would have to believe the patient and stress to the physician to give him the MSIR for relief.
3. I think I would try my best to advocate for the patient and possibly start at a very low dose of MSIR Elixir and observe his response. I would have to consult with the nurses and the doctors by sitting down to discuss this case. He may have been an addict, but he is having persistent pain now from a very real disease and condition. There is no way we can actually determine if he is a drug seeker in this case. To help him be more educated

Jason Lohmeyer 10/11/10 8:27 AM
Comment: Why? Opiod addiction when treating pain is rare.

Jason Lohmeyer 10/11/10 8:28 AM
Comment: Limited understanding of the question expressed: These fears needed to be addressed:
✓fear of making the patient an addict
✓fear of loss of control as the health care provider ; fear of being duped
✓fear of malpractice--if patient sues you for making him an addict
✓fear of regulatory review
✓fear of respiratory depressions--esp. for nurses the "I gave the last dose then he died"
✓fear of negative sanctions by colleagues or hospital

Jason Lohmeyer 10/11/10 8:29 AM
Comment: But remember those with addictions have higher tolerance and require higher dosing with narcotics.

Jason Lohmeyer 10/11/10 8:31 AM
Comment: -2
Limited discussion of question:
possible criteria for drug addiction--it will likely look something like this:

a)body language
b)facial grimacing
c)clock watching
d)demanding behavior
e)finding used syringes/needles in the room
f)being overly sedated after "friends" visit
g)any past history of drug abuse
h)asking or demanding specific drugs
i)having drug allergies to many opioids (typically to morphine but not to Dilaudid or Demerol)
j)admitting to living in an environment where family/friends are actively using drugs

items a-d are consistent with either true addiction or pseudo- addiction there is no way to differentiate without further information or a trial of better pain relief. Items e-f are pretty good indicators of true addiction, esp. e). Items h) , i) and j) are suggestive but not diagnostic, item g) only indicates past history but says nothing about the present.

The total pattern of behavior and current and past history is necessary to make the diagnosis of substance abuse. Ensure that everyone understands the definitions and differences between tolerance, physical and psychological dependence (addiction) ... [1]

about his condition, we should sit down and discuss this with him and any friends or family members that would be present.

Jason Lohmeyer 10/11/10 8:33 AM
Comment: Peter – you provided no evidence to support your discussion. You needed to discuss in depth the consequences of untreated pain in this patient and that the patient has a right for his pain to be controlled. The patient and the whole team should be involved with the treatment plan and if the MD has issues, find a new MD.
-2

Case #2 21/25

Case Study #3

1. For starters, the patient has COPD, which is an obstruction of the lungs and already puts him at a risk for difficulty breathing. The use of opioids and increasing dosages also put the patient at risk for respiratory depression (2009 Nursing Drug Handbook).
2. Different measures can be taken for this patient while he is asleep. It was not mentioned that he was on oxygen at all, so oxygen via a nasal cannula, CPAP, or BIPAP machine can be used to help his oxygen delivery. Respirations at that low rate would qualify the need for Narcan, which is the opioid antagonist, which will reverse the effects of the Oromorph. This may cause the patient to be in extreme pain, but will pull him out of respiratory depression. It is important to know that he is terminally ill and already in hospice care, so bringing him back into that much pain is against his wishes. The most important thing in the patient's mind is to control his pain. He is most likely a DNR and that might be considered an act to bring him back from his dying process. My initial thought would be to take action, but the patient understands that death is imminent and being comfortable is more important to him.
3. I would not consider this euthanasia. The patient requests whatever need to be done to keep his pain away and that is what the nurse is doing. Yes, the nurse may be aware of the effects morphine has on the body, but the patient did not request to speed up his

Jason Lohmeyer 10/11/10 8:36 AM
Comment: Why and how? We give oral MS to aid in treatment of shortness of breath (dyspnea) and it does not cause resp. depresson.
Limited discussion: **-4**

Jason Lohmeyer 10/11/10 8:37 AM
Comment: Peter – do you give Narcan to a hospice patient???

Jason Lohmeyer 10/11/10 8:37 AM
Comment: Actually not all the time. It is horrible for the patient, they go thru withdrawal symptoms and it takes hours to days to get their pain back under controlled.

Jason Lohmeyer 10/11/10 8:38 AM
Comment: Why?

death, but rather keep his pain controlled. As a nurse, it is important to document the patient's requests clearly to avoid getting in trouble with anything. From my experience in the hospital, patients request as much morphine as needed to take care of their issues with pain. It is not seen as wrong to make sure the patient is comfortable no matter what.

Jason Lohmeyer 10/11/10 8:39 AM
Comment: Remember it is the intent – if my intent in giving the morphine is comfort and the patient dies that's okay – called double effect.

Case #3 25/25

Case Study #4

1. The pain the patient is experiencing on the right side of his pelvis would be considered deep somatic pain from structures being pushed on by the tumor metastases. The sharp shooting pain that radiates down his leg is most likely neuropathic pain which is following a nerve down his leg.

Jason Lohmeyer 10/11/10 8:40 AM
Comment: Mixed pain type

2. The analgesia should begin after the XRT has begun no later than two to three days after. The radiation is meant to reduce the size of the tumors that are causing pain in different locations because of the pressure on different organs. Concurrent use of analgesia should be used to help ease the pain associated with this and side effects that may occur from the radiation (asrt.org).

Jason Lohmeyer 10/11/10 8:41 AM
Comment: Not correct APA – not on reference list

3. Maximum benefit from the XRT would be seen after it is finished approximately two to four weeks after XRT has been completed.
4. To provide better analgesia, I would likely switch to a Patient Controlled Analgesia (PCA). This way, the patient can control when he gets dosages of medication and can provide a much more consistent amount of medication in his body. If his pain returns every 1-2 hours, I could possibly cut the dosage down and give at much more frequent intervals in the IV form for quicker results as well. Another medication that can be used

effectively is a fentanyl patch that would provide consistent amount of analgesia over a 24 hour period. Fentanyl actually is 50 times stronger than Morphine and the fact that it is a patch it is a consistent amount throughout the day, even when the patient is sleeping.

Jason Lohmeyer 10/11/10 8:43 AM
Comment: Actually it is 80 times – difficult to titrate this product as transdermal patch

Jason Lohmeyer 10/11/10 8:44 AM
Comment: The correct answer was to increase morphine by 50-100% - having long acting and IR morphine dosing
-2

5. Other adjuvant drugs that I would consider would be a stool softener to oppose the effects of the opioids, which can cause constipation (2009 Nursing Drug Handbook). Also, the doctor could use Cortizone injections to act as a block to the neuropathic pain shooting down his leg. Also, the patient could be provided with anti-depressants to control his feelings that the pain can bring about.

Jason Lohmeyer 10/11/10 8:45 AM
Comment: actually patients need a softner AND a stimulant laxative (Senna S) 1-4 tabs BID

Jason Lohmeyer 10/11/10 8:47 AM
Comment: Remember that antidepressants help on a chemical level with neuropathic type of pain – and helps mood.

I was looking for gabapentin titratation, NSAIDS for pain pain and steroids
-2

6. Massage therapy and acupuncture could be used to help control the pain. Providing a more comfortable bed or more pillows for the patient could also aid in providing comfort for the patient. Cold and hot presses can be used to help soothe the pain caused in different locations.

Jason Lohmeyer 10/11/10 8:47 AM
Comment: Relaxation!

7. Patient Controlled Analgesia would be the first recommendation I would have to help control his pain. As previously mentioned, this has many benefits of pain control and he can get much more consistent control over his pain. The second recommendation I would have would be IV Morphine injections whenever pain is present as appropriate dosing intervals. The third recommendation I would use would be possible epidural or spinal blocks to cut off the feeling below a certain point in his body. This will provide comfort of pain, but will have other side effects like the inability to use the lower half of his body.

Jason Lohmeyer 10/11/10 8:48 AM
Comment: Good ideas

Case #4 21/25

Peter:

You have not provided significant references. The assignment states:

Answers should reflect in depth understanding and application of material from Module 3. References should be provided to support your ideas if appropriate (and it is appropriate). APA format is expected.

Failure to provide references -10 points (2 references in text)

Case #1-4 = 82 – 10 no references = 72/100

Peter:

I feel that from your work above that you did not spend significant time on this assignment as reflection in the fact you had no evidenced based research to support your answers. I understand that life is crazy busy, and the Mod 3 Quiz was very difficult; but I feel that you may not have completed the learning activities and viewed the powerpoints since none of those concepts were directly addressed or cited in this document. I will give you until this Thursday at 11:00 AM to revise any the questions that I did not provide you with the answer/suggestions in my comment box. Please resubmit this via the dropbox. The most points you can get on it will be 15. If you have questions contact me. Jason